

Coroner's Inquest Review Panel Members VIA: Sabra Smith-Newby, Assistant County Manager

## Dear Panel Member:

Based on my interactions with you as a panel over the last three Monday nights, as well as interaction with the law enforcement community, I am going to make a number of recommended changes to the Coroner's Inquest process. These changes will parallel and/or be very similar to the recommendations I made at our most recent meeting on November 1<sup>st</sup>. I am flexible in regards to the recommendation that I am making. Therefore don't take the attached information as a motion on my part, but further giving us a defined road map as we move forward on the recommended changes.

Attached to this letter will be a flow chart. The flow chart is intended to give you, as well as other individuals present for the meeting Monday, an idea of how I see this process flow from the incident itself to a final determination of criminal intent on the part of the District Attorney. Some aspects of this flow chart may not necessarily be impacted by the Coroner's inquest ordinance itself, but based on the feedback from you and the public, I think it's important from a communications piece that we continue to push out the totality of circumstances surrounding an officer's use of force that results in death.

I know we have to be careful in regards to open meeting laws and interaction; however, I am in town and of course available to each one of you if you have specific questions in regards to my recommendations. Please don't hesitate to call me on my cell, 702-812-0013, and I will return your call as soon as possible.

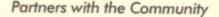
I look forward to seeing all of you again this coming Monday night and finalize our recommendations for the Coroner's inquest process.

Sincerely,

Douglas C. Gillespie Sheriff

DCG:dlk





Coroner's Inquest Review Panel Members
VIA: Sabra Smith-Newby, Assistant County Manager

## To all Panel Members:

My intent of this particular letter is to give you an overview of my recommended changes to the inquest process. I will follow this up with more specific wording in regard to the inquest process itself, but I believe this will help follow the attached flow chart

Use of Force Incident: An incident occurs where a police officer, acting in capacity, uses force or death occurs. Under these circumstances an initial investigation response would take place.

Based on the respective law enforcement entities an investigative component would roll out to this specific incident. At the Las Vegas Metropolitan Police Department two components would respond. First is our Force Investigative Team who conducts the criminal investigation, as well as the Critical Incident Review Team who looks into the incident from a training and tactics standpoint. A preliminary investigation is completed and normally in a very short period of time, less than a day, contact is made with the District Attorney's (DA's) office in regards to the use of force.

If on the surface this appears not to be criminal in nature, contact will then be made via the DA's office with the Coroner's office. At that time a decision will be made in regards to holding of an inquest. If it's determined at this level that it appears criminal charges may be apparent, we would not move forward with the trigger for the inquest. However, in the overwhelming majority of these cases the criminal intent of the officer is not in question and it would be appropriate to contact the Coroner's office in regards to the triggering of the inquest process.

Once the inquest process is triggered, the Coroner will advise the Chief Judge of the Eighth Judicial District Court of Nevada. The Chief Judge will then select from a panel of judges a judge who would be the presiding officer for the particular inquest. I believe limiting these judges to a number of 10 would be more appropriate for the selection processing. An understanding of the Coroner's inquest process and the intricacies of it, I think are important for its streamlining or efficiency aspect; however, this only a recommendation on my part.

Once the presiding officer has been selected some time may proceed before an initial meeting with the Coroner, the DA, and the presiding officer. The reason being is the completion of the investigative file. Once the investigative file, as well as the Coroner's file, is completed a meeting with the presiding officer should be held with the Coroner and the DA's office. At that time the presiding officer will get an overview of the particular case, have an opportunity to look at the file if they so choose to, and also gain understanding in to the Coroner's inquest process and the intent of the process.

Once this meeting has been concluded the presiding officer will schedule a discovery meeting. The intent of this meeting will be to have the DA, the Coroner, the presiding officer, representatives from



the family of the decedent, and representatives from the officers all present. In the past this has been referred to as interested parties and, of course, that current definition could be used. In addition, there will be a representative that has been referred to as an ombudsperson that would be the spokesperson for the community, to include the officers as well as the family. This ombudsperson would be present for this discovery hearing. Everyone that I have mentioned would have access to the investigative file as well as the Coroner's information. They would be given a period of time that the presiding officer would decide to review these particular files. Also at this time a date for the inquest would be set no more than 90 days from the day which this discovery meeting is held.

Within the next 30 days the interested parties, their representatives, as well as the ombudsperson, the DA, and the Coroner will again have a meeting with the presiding officer. At that time the scope of questioning and witnesses that would be called would be discussed and decided upon by the presiding officer. The presiding officer should have final say and their determination cannot be appealed to a higher level.

Once the foundation for the questioning and the inquest has been established, the interested parties may have individual interaction with the ombudsperson in regards to their specific areas of concern, meaning questions they feel should be asked of the witnesses that have been selected to appear at the coroner's inquest. It will be the sole responsibility of the ombudsperson to follow up on any of the facts presented by the DA's office at the Coroner's inquest itself. I see the ombudsperson as being an independent third party who has the ability to further query any of the witnesses on the stand, thus eliminating the need for any questions to be submitted by any interested parties.

As I stated before, a date is set for the inquest itself. The inquest is then called. A panel is selected from the jury pool that will sit. There will be a number of interrogatories that will have been established by the presiding officer that will require the panel's determination at the conclusion of the inquest. These interrogatories, similar to those in Seattle, should be very narrow in scope and very focused on the particular incident. The intent is not to determine guilt or incident, nor policy, procedures or training deficiencies; more importantly a public acknowledgement of the facts of the case.

Once the panel has been seated the Coroner's inquest will proceed. The DA will continue in their role as the presenter of the facts. A witness will be called. The DA will introduce that witness; they will go through the scope of questioning. The ombudsperson will follow up and ask questions or redirect or cross examine. The witness is then excused and we follow the process under a normal, criminal proceeding. Once all of the witnesses have presented their information and the facts of the case have been presented, the judge will give the opportunity for the panel to determine their findings. Once the findings have been determined by the panel, they will be read in public.

When the proceeding is concluded the DA's office, in a time period established by the DA, will make a public acknowledgement of whether criminal charges will be filed against the officer. I believe this will bring closure not only to the facts and circumstances surrounding the incident, but also that of whether or not criminal charges at this particular time will be filed or not.

From a couple of procedural notes: in regards to the ombudsperson, my recommendation is that we seek retired judges to participate in this process. Because of the number of incidents that may occur, I would recommend a number of 7 to 10 retired justices. These individuals would be paid for the work and they would also be selected and appointed by the Clark County Commission. That pool then can be drawn from for the Coroner's inquest. I have heard the concerns of my fellow panel members in regards to having multiple ombudspersons, but my thought would be rather than say it can't work, let's give it a try and see if it can work. Let's do our best to keep it from becoming competing ombudspersons or attorneys in this setting, but more importantly candid questioning by a truly independent third party that has had discussions with both the officers as well as the family in regards to the particular incident.

Interrogatories: I believe interrogatories are important. I believe there has to be some type of determination made by the inquest panel. I think it's important to continue with the panel because truly they are the voice of the community. I think it brings credibility to the process. We have talked often about the outside looking in, and I think if you eliminate the panel you eliminate what may be down the road that perception that this process isn't as transparent as it needs to be.

I believe as we continue to move forward in this particular process we must stay focused on the fact finding aspect of what it is we are doing. We are not here to determine training levels; we're not here to determine policies and procedures. We are not here to determine criminal intent. We are here to let the public know what happened.

Sincerely,

Douglas C. Gillespie, Sher

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